

S. No. 2
M-543
7. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37942
Registrar's No. 317

Registration District No. 146 Primary Registration District No. 3026

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County JACKSON
(b) City or town INDEPENDENCE
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
820 W. LEXINGTON
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1
(Specify whether years, months or days)
In this community ABOUT 40 YEARS

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County JACKSON
(c) City or town INDEPENDENCE
(If outside city or town limits, write "RURAL")
(d) Street No. 820 W. LEXINGTON
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country NO

3. (a) PRINT FULL NAME AMANDA M. JOLLEY
3. (b) If veteran, name war NO 3. (c) Social Security No. NO
4. Sex FEMALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife WILLIAM C. JOLLEY
6. (c) Age of husband or wife if alive 13 years 1852 (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 11 day 27 year 1944 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from 1935, 19 , to Nov 27, 1944
that I last saw her alive on Nov 26, 1944
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
91 11 14 _____ hr. _____ min.

Immediate cause of death Central thrombophlebitis Duration 30 days
Due to arteriosclerosis chronic

9. Birthplace NEW WASHINGTON OHIO
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) 830!
Major findings: Of operations _____
Of autopsy _____

10. Usual occupation HOUSEKEEPER
11. Industry or business NONE
12. Name VOLNEY POWERS
13. Birthplace NO RECORD
14. Maiden name MARY REEM
15. Birthplace NO RECORD

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant HENRY W. STAHL
(b) Address 815 W. MAPLE AVE.
17. (a) BURIAL (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation MOUND GROVE

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

18. (a) Signature of funeral director Henry W. Stahl
(b) Address 815 W. MAPLE AVE.
19. (a) 11-28-44 (b) James W. Ross
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) (c) Means of injury _____
23. Signature J. H. Hekerson (M. D. or other)
Address Independence, Mo. Date signed Nov 28/44

(Licensed Embalmer's Statement on Reverse Side)

1163

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ~~or by~~.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *Henry W. Stahl*.....

Licensed Embalmer No. *3181*.....

P. O. Address *Independence Mo*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.